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## Original Articles

Older Women Living with Domestic Violence:  
Coping Resources and Mental Health and Wellbeing

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## Abstract

**Background** Domestic violence represents a serious public health issue for women and their children worldwide. International evidence suggests that women aged over 50 who are victims of domestic violence are suffering in silence because the problem is ignored by professionals and policy makers. More UK research is needed to identify the extent of the problem, and services to meet the needs of older women. **Study aims** To bridge this gap by seeking to gain a deeper, systematic understanding of how 'older women' cope with domestic violence and how it effects their wellbeing, using a theoretical framework of 'salutogenesis' to consider coping resources used in lifelong abuse. **Methods** The study recruited a convenience sample of eighteen older women who are currently, or had been in an abusive relationship. A semi-structured interview schedule was used to discuss the personal nature, of domestic violence in their lives, and the pattern of abuse over time and its effects on their wellbeing, ways of coping and sources of support, barriers to reporting and accessing support, and experiences in seeking help. **Results** Living in a domestically violent context has extremely negative effects on older women's wellbeing. Living with a perpetrator of long-term violence is predisposing these women to extremely negative health outcomes such as Post Traumatic Stress Disorder, anxiety and depression. Three-quarters of the women defined themselves as in poor mental health and were using pathogenic coping mechanisms, such as excessive and long-term use of alcohol, prescription and non-prescription drugs and cigarettes. This negative coping increased the likelihood of these women experiencing addiction to drugs and alcohol dependence and endangering their health and wellbeing in the longer term. **Conclusions** Public health interventions can work well from a 'salutogenic' perspective by finding ways to promote healthy behaviours that increase older women's sense of wellbeing and coping. The application of this theoretical framework offers the potential for new knowledge to contribute to the discourse about wellbeing in older women dealing with domestic violence.

**Keywords:** domestic violence; abuse; older women; wellbeing; coping resources; sense of coherence.

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## Introduction

Violence is a major public health issue internationally, and domestic violence (DV) in particular, represents a serious public health issue for women and their children [1]. Worldwide, 20 to 50% of women suffer physical, emotional, or sexual abuse at some point during their lifetimes [2]. For older women it is a common experience; approximately 15% of women aged over 50 years [3] have experienced some form of DV and this can occur well into later life [4]. Although women are the majority of the older population in virtually all nations of the world [4], little research globally has been given to the support needs of older women in this respect [6]. In fact, their voices are virtually absent from the research literature as service providers and policy makers often assume that domestic violence stops at around age 50 years. This results in a noticeable lack of guidelines on the issue, and little development in responsive community prevention and intervention programmes [7-9]. International research on the issue of older women and DV is relatively recent [10-14], and much of the literature is from the US [15-17], and not always applicable in the UK context. There have, however, been four recent small-scale studies in the UK, three specifically on DV against older women [18-20], and one more generally on abuse of older women [21]. These studies highlight that women aged over 50 who are victims of DV are suffering silently because the problem is often ignored by many professionals and policy-makers. Evidence also suggests that older women face serious barriers to accessing support and are offered few appropriate services when they manage to enter the service system [21-25].

The negative mental health consequences of DV have been well documented and show that symptoms of Post Traumatic Stress Disorder (PTSD) and other psychological stress reactions are long-term mental health consequences of DV [14, 16, 20, 21]. Domestically abused women are 3 times more likely to be diagnosed with mental illness [26], 3 times more likely to report depression [26, 27], 5 times more likely to attempt suicide [28], 9 times more likely to misuse drugs [29], and 15 times more likely to misuse alcohol [29]. Depression and PTSD, which has substantial co morbidity, are the most prevalent mental-health sequelae of DV [25, 30], with low self-esteem, and feelings of inferiority height-

ening the risk of re-victimization [25, 26]. Long-term effects for older women who may have experienced trauma for 30-40 years include: permanent physical damage, chronic eating disorders, disability, self-harm, self-neglect, loss of confidence, mental health problems and a significant link to suicide risk [31]. Recent evidence suggests that psychological violence is the most common form of abuse for older women [19, 20]. In addition to the direct psychological effects, abuse may negatively affect the factors that improve mental health and wellbeing [14, 29].

## 'Salutogenesis' creating positive mental health and wellbeing

Creating positive mental health wellbeing or *salutogenesis* is a well-established concept in public health [32]. A *salutogenic* approach provides a particular perspective to the way health is viewed, which is centred on the discovery and use of personal resources, either inside a person or in the environment, that maintain a healthy status [33]. Antonovsky [33] developed the theory of *salutogenesis* that focuses on how wellbeing is shaped by socio-cultural factors of the individual, their family and community, and that life experiences produce positive ways of coping and adapting to situations, an approach to health that is highly consistent with the main ideas in the Ottawa Charter for Health Promotion [32]. The salutogenic approach has been described as a deep personal way of being, thinking and acting. Some fundamental concepts came out of Antonovsky's primary research and these have been investigated further in recent years [34, 35]. These core salutogenic concepts are *generalised resistance resources* (GRRs) and a *sense of coherence* (SOC) or 'wellbeing', tools that are useful in the maintenance and development of wellbeing. GRRs can be promoted in structures such as childhood experiences, social support and family relationships [34]. It is thus possible that professional groups or individuals could be described as GRRs too. According to Antonovsky, people who have sufficient and adequate GRRs at their disposal and learn how to use them can gradually develop a stronger sense of coherence (SOC). Individuals with a strong SOC tend to cope with the stressors of life better and, inversely, people with a weak SOC tend to be more vulnerable to ill health [35]. It is believed that individuals develop their SOC

throughout life but it can be strengthened by health promoting and support interventions, moving people toward the health pole of the continuum [32]. Although the theory is well established in general health, the fundamental principles of the theory and their implications for promoting wellbeing have not been discussed thus far. The present study uses ‘salutogenesis’ theory to debate how older women cope with DV, and how it affects their mental health and wellbeing.

## Present Study

The WHO conceptualizes mental health as not merely the absence of mental illness but the presence of ‘a state of wellbeing in which individuals realize their own abilities, can cope with the normal stresses of life, work productively and fruitfully, and are able to make a contribution to their community’ [9]. Coping is seen as a multidimensional, dynamic process designed to make tolerable the mental health effects that stressful situations engender [36, 37]. To date, the extensive literature on coping and DV has focused almost exclusively on younger women and little is known about how older women cope with lifelong abuse, and how it affects their wellbeing [38–40]. This Northern Ireland study aims to bridge a research gap. To our knowledge this is the first study to gain a deeper understanding of how ‘older women’ cope with DV and how it affects their wellbeing, using a theoretical framework of ‘salutogenesis.’ As this study sought to understand women’s own experiences a qualitative approach was best suited to meet the research aims.

## Methods

### *Sample*

Convenience sampling of those women who are currently, or had been in abusive relationships since age 50 was considered the most appropriate method of identifying abused women to participate in the study. Participants were recruited by Northern Ireland Women’s Aid (WA) staff between March–September 2009 employing a number of strategies, including flyers and word-of-mouth. A major consideration was to ensure the safety of participants, an important selection criterion being that all women recruited would receive support from WA if required. Whilst this might be considered as a limitation of the study, it was necessary in order to ac-

cess this vulnerable group of women who are not always easily visible to health and social services. The operational definition of ‘older’ was women age 50 and over, which corresponded to research studies in the area [41, 42].

### *Ethical and Safety Recommendations*

Two skilled female researchers undertook the semi-structured interviews in complete privacy at a convenient time lasting between 1 and 3 hours. The researchers were careful to ensure confidentiality and safety (emotional and physical), as well as sympathetic support, for the women interviewed. Women who have been disempowered by abuse are reluctant to give away power to researchers and so a process to consult them fully and to obtain their written informed consent for involvement was developed with careful consideration given to support issues. With permission, all interviews were audio-taped and transcribed, and women were provided with information on support services that could respond to their situations. Confidentiality was respected at all times to ensure women’s safety and names removed from all data. Data was held in a locked room within the University. The research protocol and informed consent forms were approved by Women’s Aid and the Ethics Committee of the School of Social Work, Queen’s University.

### *Procedure*

The study used a narrative approach which emphasizes the way people, as story tellers, construct their cognitive world and define their personal identity. Personal narratives of older women living with domestic violence provides a deep perspective as it includes richness of thoughts, emotions and experiences that reflect personal, interpersonal and social processes that assist in understanding and constructing their life with DV. Face-to-face in-depth interviews were developed from evidence-based material relating to domestic violence and older women according to the narrative tradition and included: effects of abuse on perceptions of life experiences, intimate relationship with partners, family relationships, all described throughout the course of life; current demographics; type and length of abuse; coping resources and support networks; barriers to seeking

help; physical and psychological effects; current self-reported health and mental health status and relationship issues; use of drugs, smoking and alcohol; childhood abuse.

## Data Analysis

Thematic framework analysis based on ‘salutogenesis’ theoretical dimensions were used to explore their ‘wellbeing and coping’. SOC comprises four dimensions, that is: comprehensibility; manageability; meaningfulness; and emotional closeness. Comprehensibility means that whatever happens to a person, she is able to make cognitive sense of it and understand it as structured, predictable, and explicable. Manageability is a psychological component which means that either internal resources are available to meet the demands posed by the stress, or there are ways to access resources externally. Meaningfulness is interpersonal and involves having a sense of meaning in the important areas of one’s life or recognizing these demands as challenges, worthy of investment and engagement. Emotional closeness involves having inner strength and feelings of being nurtured.

## Results

### Sample Demographics (Table 1)

#### Comprehensibility (Cognitive)

All women understood the effects that DV had upon their wellbeing, by self-reporting their current health status as ‘poor’ (e.g. chronic pain and fatigue, arthritis, IBS, asthma, hypertension, depression, fear, anxiety). Physical abuse was more prominent in the early years of marriage when children were smaller, with 10 women experiencing severe physical trauma such as gunshot and knife wounds, broken jaws, teeth and limbs. Twelve women felt that the most violent attacks were during times when their husbands were drinking heavily. For half the women the birth of their children and postnatal depression (PND) had an impact on the violence, a condition not understood by their husbands, or by their GPs, and often led to bouts of severe physical and verbal abuse.

*‘Violence in my early years was extremely physical, he battered me emotionally and physically but violence in*

*my latter years has been more psychologically threatening and devastating for my life in general.’ (Mary)*

*‘After our first baby was born I suffered what I now know was postnatal depression and my husband and I fought very violently at this time. It started with slaps around the face and then moved to punches to my head and neck. He would hit me quite hard if I cried because I was depressed and he would shout at me ‘to snap out of it’. He would tell me to toughen up and stop acting like a child. I soon learnt to keep my feelings and emotions private from him as any show of emotional distress from me would warrant physical beatings. I also had no sexual feelings at this time and he would violently force me to have sex and I would cry myself to sleep.’ (Margaret)*

*‘He often hits me so hard on the back of the head that I lost hearing in one ear. ..I had ringing in my ears for some time and on two occasions I bled quite badly. He would laugh and say that no one can see the bruises as they are hidden by my hair. (Annie)’*

Over a third were exposed to violent sex or forced to have sex against their will which left them feeling traumatized, degraded and frightened.

*‘When we were first married he would be very violent during sex and this frightened me. I was often left black and blue ... he told me that this was normal and that I was exaggerating as usual. If I said no to him he would hit me with a belt.’ (Fern)*

Almost all talked about their childhood abusive experiences before marriage: 4 women had been sexually abused as teenagers; 10 reported physically abusive relationships and lived with family violence.

*‘My abuse started when I was eleven with my father. He sexually abused me and that went on for eleven years... Now these are people you trust and when people you trust do this to you your whole foundations are rocked and your whole perception of trust is broken with anybody you know’. (Mirium)*

*‘My mother was very hard on me when I was growing up. She was physically very abusive to me when I was a child. She would have hit me all time and was always putting me down... She locked me in my bedroom many, many times. She made my life miserable with name calling and abusive language’. (Winifred)*

Table 1. Older Women and Domestic Violence: Effects on Health and Mental Health (n=18)

	N	%
Age (mean 61 years) Range (53-72 years)	18	100
Married in Relationship (range 21-42 years)	14	78
Divorced	4	22
Duration of Abuse (mean 39 years)		
Children	16	89
Caring Role for Partner	10	56
General Health: Self-reported Health Status		
Poor	18	100
Currently on prescribed drugs (physical complaints)e.g. Hypertension, Headaches, IBS, Chronic Fatigue, Chronic pelvic pain, Arthritis, Asthma	18	100
Mental Health		
Postnatal depression	9	50
Severe Anxiety/Fear	16	89
Severe Depression	17	94
Constantly afraid/anxious	16	89
Nervousness/inner restlessness	15	83
Low self-esteem	14	78
Obsessive-Compulsive Disorder (OCD)	4	22
Bi-polar Illness	3	17
Suicide Thoughts	1	6
Currently on prescribed drugs (psychological complaints) e.g. Severe anxiety, Depression, Bi-polar disease, OCD	18	100
Abuse Characteristics		
History of child physical abuse	10	56
History of child sexual abuse	4	22
History of growing up with domestic violence	3	17
Current Violence in the Relationship: Type of Abuse		
Physical abuse	0	0
Severe physical violence	0	0
Psychological/Emotional abuse	18	100
Sexual abuse	1	6
Financial	8	44
Social	10	56
Past Violence in the Relationship: Type of Abuse		
Physical abuse	12	67
Severe physical violence	10	56
Psychological/Emotional abuse	18	100
Sexual abuse/Forced Sex	12	67
Financial	12	67
Social	14	78
Nature of Injury		
Minor	12	67
Severe	10	56
Bruising	14	78
Cuts/Abrasions	14	78
Broken bones	11	61
Knife wounds	4	22
Gun shot	1	6
Broken teeth/jaw	6	34
Medical Attention		



GPs	13	72
A&E	10	56
Psychiatrist	4	22
<b>Use of Drugs</b>		
Over the counter Painkillers/Codeine	11	61
Sleeping tablets	10	56
Tranquillizers	14	78
Antidepressants	16	89
Addicted to 'valium'	6	34
Addicted to painkillers	4	22
<b>Use of Alcohol</b>		
Alcohol Dependent	4	22
Heavy drinking	6	34
Moderate drinking	2	11
Minimal drinking	4	22
Stopped	2	11
<b>Alcohol/Drugs during Violence</b>		
Partner's use of alcohol/drugs during violent attacks	12	67
Victim's use of alcohol/drugs during violent attacks	8	44
Violence reported to the police	9	50
<b>Relationship with Children</b>		
Good support	6	34
Poor support	9	50
No support	3	17

Table 2. Effects of Domestic Violence on 'Older Women's Sense of Coherence General Resistance, and Coping Resources'

Sense of Coherence 'Wellbeing'	General Resistance Resources' (GRRs) 'Protective Factors for Wellbeing'	Effects of Domestic Abuse on 'Older Women's Wellbeing'
<b>Comprehensibility</b> (Cognitive)	<b>Physical Wellbeing:</b> ✓ <i>Having positive childhood experiences</i> ✓ <i>Ability to control stress/fear reaction</i> ✓ <i>Inbuilt resilience</i>	<ul style="list-style-type: none"> <li>▪ <i>Negative childhood experiences</i></li> <li>▪ <i>Prolonged lifelong effects of abuse &amp; trauma</i></li> <li>▪ <i>Stressful effects of living with fear &amp; intimidation</i></li> </ul>
<b>Manageability</b> (Psychological)	<b>Mental Wellbeing:</b> ✓ <i>Positive thinking</i> ✓ <i>Self-esteem</i> ✓ <i>Positive life experiences</i> ✓ <i>Coping resources</i>	<ul style="list-style-type: none"> <li>▪ <i>Detrimental effects on wellbeing &amp; poor mental health</i></li> <li>▪ <i>Negative coping resources</i></li> <li>▪ <i>Addiction</i></li> </ul>
<b>Meaningfulness</b> (Interpersonal)	<b>Interpersonal Wellbeing:</b> ✓ <i>Support from friends</i> ✓ <i>Health professional support</i> ✓ <i>Access to community support: e.g. police, Women's Aid</i> ✓ <i>Financial supports</i>	<ul style="list-style-type: none"> <li>▪ <i>Limited health professional support</i></li> <li>▪ <i>Limited support needs &amp; barriers to help seeking</i></li> <li>▪ <i>Concern for abuser</i></li> </ul>
<b>Emotional closeness (Emotional)</b>	<b>Emotional Wellbeing:</b> ✓ <i>Good emotional support</i> ✓ <i>Inner strength</i> ✓ <i>Feeling empowered</i> ✓ <i>Close family bonds</i> ✓ <i>Feeling loved</i>	<ul style="list-style-type: none"> <li>▪ <i>Feelings of loss, hopelessness &amp; powerlessness</i></li> <li>▪ <i>Living with shame, guilt, self-blame &amp; secrecy</i></li> <li>▪ <i>Loneliness &amp; isolation</i></li> </ul>

### **Manageability (Psychological)**

Over time a more cruel intense and damaging psychological abuse developed, that eroded these women's lives, self esteem and ability to nurture, and which they insisted was worse than physical trauma. All related how unrecognized they felt the problem of non-physical abuse was and described it as "totally invisible" and the prominent form of abuse in older age. Their abusers used a variety of non-physical manipulating and controlling behaviours which led to feelings of loss, terror, hopelessness and powerlessness, and a sense that they had nowhere to go or anyone to talk to:

*'The verbal hatred is worse for me. Bruises heal in time but words last forever. When you are told over and over how stupid, ugly, and insane you are, you really believe it. I have panic attacks and take tablets to calm my nerve ..., life is dreadful and I see no way out as I have nowhere to go and I am not financially nor physically capable of going anywhere.'* (Frances)

Psychological effects of domestic abuse produced severe depression and a sense of loss, a loss of self, confidence, family life, income, and sexual partnership, and most of all a loss of a loving relationship. Subtle non-physical abuse like constant ridiculing, verbal insults, threats, intimidation, humiliation and long silences were more effective in controlling a woman than physical violence, in that concealed abuse alternated with loving behaviour seemed to increase the woman's uncertainty about herself and her ability to cope.

*'I coped by going into my own private world ...; I took Valium ... I saw myself as a failure and felt sorry for myself... 'I withdrew from family and friends; 'I didn't think about it and prayed that it would go away'; 'I always thought it would improve and things would get better ... was I wrong!'* (Helen)

*'When I travel alone I pretend to be someone else. This allows me to block out memories and I can pretend that life is good. If I didn't live in an alternate world, away from the fear and despair, I really don't know what I would do' Add alcohol to this and I am happy for the short term.'* (Iris)

Most women felt that there was no help available for women of their age, particularly for those who experienced psychological abuse.

*'He is still very moody and bad tempered even after 40 years. We live and sleep in separate rooms. He even eats different things. My life is miserable and I only have an existence. He sometimes won't acknowledge me for a week at a time. When he does he complains about my cooking, or what I do. He shouts violently and gives me verbal abuse for anything and everything. He breaks glasses and vases in front of me just to frighten me. I try now to block it all out. No friends or family come and visit as he still hates everyone including all of the children. My children hate him for what he has done to me.'* (Claire)

Mental health issues were prominent with 17 women being seriously affected by depression and anxiety for most of their married lives and were currently prescribed tranquillizers, anti-depressants and sleeping tablets. Six women were being treated for addiction to tranquilizers. Alcohol and drugs were used as negative coping mechanisms. Health was compromised by substance misuse by more than half, who were using non-prescription drugs such as codeine, paracetamol, decongestant cough and cold remedies, antihistamines, as agents along with alcohol to help them cope better with their lives, or make them drowsy and sleep better. Twelve women had pressurized friends and family to give them their prescription drugs such as tranquilizers (valium) or stronger painkillers to help them cope, but soon found themselves addicted to these drugs.

*'He (my husband a GP) got his medical partner to prescribe Valium for me in the 1970's and I am still taking it, especially when I feel hopeless and in despair. I know that I am addicted to it and worry that at 68 years I will never be able to survive without them. They are my happy pills. I cry when I take them and cry when I don't.'* (Winifred)

Alcohol was used by most to calm their nerves, or lift their spirits. Most were drinking far in excess of normal limits and 4 women who had been diagnosed as 'alcohol dependant' attended Alcoholics Anonymous.



*'He (my husband) was always a heavy drinker and he was his most violent when he had been drinking. The irony is that I only started drinking because I was frightened of the physical abuse... Now I drink much more than he does and I know it is affecting my health badly, my nerves and stomach (perhaps my liver) are wrecked, my blood pressure is sky high, and my children see me as an 'old drunk'. I feel ashamed as my children think that I am inadequate and can't cope with life in general.'* (Evelyn)

*'I drank heavily at one stage to help me sleep as it dulls your senses. I also took up to 30 codeine tablets each day... I have had liver function tests taken and my GP has told me that I have compromised my liver with all the drugs and alcohol I have taken over the years'.* (Anne)

*'Alcohol is now my partner, my friend, my soul mate, all because I have no one to love me. My husband has frightened me all of my life, he has hit me until I bleed but when I drink I forget all of these things and life appears 'normal'.* (Angela)

### **Meaningfulness (Interpersonal)**

The women expressed a number of interpersonal barriers to help-seeking. Support from family and friends was limited, likewise the response from legal and health and social care professionals. Fourteen women had limited or no support from their children, as relationships had broken down over the years mostly due to their depression and alcohol misuse. All felt a lack of community resources, and limited knowledge of the criminal justice system. General practice was seen as the logical resource for obtaining short-term help. Fifteen women had talked to their GPs about the abuse but on no occasion had their doctor brought up the topic, even though ten women had been attending the health centre and A&E with severe cuts, bruises, panic attacks and evidence of physical and psychological trauma for many years.

*'My GP and the nursing staff were well aware that I was getting a beating at home, but they never said the words. I was a frequent visitor with severe cuts and bruises and no one ever asked how I got these injuries. I would even go to the clinic with other conditions such*

*as irritable bowel but they would not ask about my visible cuts and bruises.'* (Maeve)

*'I have bi-polar disease and I went to my GP in 1974 and told him that my first husband was beating me. He was totally unsupportive and didn't appear to understand my illness or the violent relationship I was in...He told me his job was to keep the marriage together regardless and that I should put up and shut up...!'* (Joyce)

*'He assaulted me badly with a hammer several times and I often needed twenty odd stitches... I went to A&E and attended my GP on several occasions saying that I had banged my head on cupboards. He would come right into the treatment room with me and the doctors and nurses never questioned me... I am sure they knew I was lying... what could they do really?'* (Evelyn)

Economic dependence was frequently cited as the most significant barrier to seeking help or leaving the abusive relationship. Financial abuse by partners included: refusal to put woman's name on property deeds, withholding his money and salary, or applying pressure for her to sign over money or assets. Money and finances were used to restrict women's movements and keep control.

*'Money that I could use for other things in my life is now being given over to caring for a husband who has treated me so badly throughout our lives together. In a way I have paid for everything for him... my life... and even all of my money'.* (Olive)

*'I think the biggest problem for a woman ... someone of an older age, or at my age is to understand that you are still a woman who can have a relationship and get a job... but how do you go about it when you have been out of it for years. Women's Aid helps me with this.'* (Joyce)

### **Emotional Closeness (Emotional)**

An important aspect described by several respondents' was the ongoing emotional connection with their partners that made punishment for the abuse unacceptable or difficult to comprehend. Although this connection was more implied than explicit in the data, it explained why some of these older women stayed in long-term abusive relationships. Over half were caring for their

abusive partners, who had a range of both medical and mental health problems.

*'I think he had Aspergers when he was younger. I know he is mentally ill now (bi-polar disease) and I have looked after him for years but sometimes I have no sympathy. The worst period of physical violence in our long marriage was after I had signed the forms for him to receive Electro Convulsive Treatment. He blamed me for his mental illness and I suffered as a consequence'.* (Laura)

Emotional concepts such as shame, guilt, self-blame were described by all women with each believing that they were in part responsible for and/or deserved the abuse perpetrated by her husband as she was unable to deal with the situation. Twelve women said that abusers exploited these feelings and emotions over time, which may have had the result of predisposing them to further abuse or preventing them from seeking help. Most women blamed themselves and felt responsible for any crime perpetrated against them.

*'I blame myself. I should have left him when I was younger. I am ashamed as I know I could have had a better life... so could my child. He treated our son so badly that when he was diagnosed with cancer he refused to speak to him or offer him support. I went to his funeral on my own. I really don't know how I have lived with a man like this for 37 years'.* (Sheena)

*'I don't really get on with my daughters now. I think it is because there was an incident when their dad was put in prison for a really bad domestic violent incident and they blamed me for him having to do 6 months.'* (Mary)

All found it difficult to seek help or leave an abusive relationship, as often they were powerless to take action to protect them or their families. The effect of long-term isolation created more profound dependency (e.g. poor job skills, small or nonexistent social support network and financial dependency). In some cases isolation seemed self-perpetuating:

*'My life is not happy or full of family and friends. I feel totally alone. My husband systematically removed them*

*from my life. A lonely life into old age leaves me with dread.'* (Beth)

*'I have lost my whole family no one comes to see me anymore. Years ago they tried to persuade me to leave him and they now feel that I don't really listen. My daughter says I am stupid and has lost patience with me, but where would I go?'* (Iris)

## Discussion

The narratives provide a powerful picture of DV experienced by older women, its effect on their mental health and wellbeing, and the unique challenges they face, as well as the coping resources they utilize in order to meet these challenges. However, it is the people we are closest to who provide the greatest effect on development of our 'sense of coherence' or wellbeing by building our coping abilities and self esteem [35]. A major finding from this study highlights how living in a domestically violent context has extremely negative effects on older women's sense of coherence and wellbeing. These women have not experienced a normal development of their sense of coherence as three-quarters suffered child sexual abuse and maltreatment or had been living with domestic violence in childhood. Also for all women living with a perpetrator of long-term violence predisposes them to extremely negative outcomes such as intense fear; anxiety and depression, resulting in a weak sense of coherence, as well as an inability to utilize their own GRRs in all four domains (Table 2). Applying 'sense of coherence' theory provided a clearer understanding of the complexity of human coping, and revealed insights into how the components of the sense of coherence concept interact with and overlay one another.

Psychological abuse had the strongest impact on women's 'wellbeing', destroying self-confidence, self-efficacy and coping abilities, removing from victims a sense that their world is logical and understandable. Under extreme stress, all women defined themselves as being in poor mental health and were using pathogenic coping resources, such as excessive and long-term use of alcohol, prescription and non-prescription drugs and cigarettes, leading to increased addiction to drugs and alcohol dependence which endangered their long-term health and wellbeing. It could be hypothesized that these women are suffering from long-term PTSD, a

state of severe emotional, mental, and physical exhaustion caused by excessive and prolonged abusive stress [43, 44]. These findings are consistent with research that describes the pervasive nature of psychological abuse, which affects all areas of a woman's life and has been associated with PTSD [45-48], depression and drug addiction [2, 5, 6, 19, 20]. Besides the inherent negative implications of increased rates of psychopathology, it has been theorized that psychopathology in and of itself may be a risk factor for continued long-term violence between partners, thus perpetuating the cycle of violence and also interfering with effective use of available community support [49-50]. The experiences of child abuse and untreated depression in early married life (e.g. postnatal depression) may have played some role in increasing the chances of becoming a victim of domestic violence and increasing susceptibility to mental illness. A key finding that corresponds to other studies is that leaving their partner may not be an option for many older women [49, 51, 52]. Regardless of the detriment to their mental health most women remained committed to their abusive relationships for reasons such as fear of being alone, loss of children and family, real or perceived financial dependency, health concerns, or because of the moral expectation that they should care for their aging partners [53].

Support networks were missing. Although the health service, in particular nurses and GPs, are in a unique position to contribute towards the assessment and identification of DV in older women and to provide access to appropriate support, they often lack training and skills, and lack awareness of the existence of DV in older women [31, 54, 55]. The narratives showed that most GPs did not take the women seriously or did not believe their situation, or distress. These findings correspond to Morgan Disney [42] who found that doctors were the professional group most likely to be accessed by older women, yet they appeared the most unhelpful. GPs are consequently unlikely to identify signs accurately [56, 57] but should be encouraged to 'begin to see' and 'begin to ask' so that they can provide adequate support [20]. As observed through the narratives stress conditions such as depression, irritable bowel and chronic pain can serve as 'red flags' for doctors to inquire about DV [6]. Since health professionals are in a unique position to identify abuse, screening for DV would allow them to address the root of a patient's

problem rather than solely treating the presenting symptoms which could lead to more efficient and effective mental health care services and improvement in the lives of victims, who are often left lonely and dependant on drugs and alcohol to cope [58]. This would also help women develop meaningfulness by supporting them as they try to take control of their lives, and involving them in decision making; and improving their comprehensibility and manageability by informing and educating them. The narratives also highlighted that nurses and GPs must enable safe disclosure by seeing clients alone, and undertake training in recognising, screening, and reporting DV in older women [59]. The British Medical Association [60] has proposed that all healthcare professionals should practice selective enquiry and routine enquiry with patients, and must recognize that strategies to tackle substance misuse must also be mindful of the strong association with DV [49, 54]. Evidence highlights that sixty percent of doctors and nurses have reported not having specific education in domestic abuse-related issues [57]. Practitioners trained in cognitive restructuring and positive thinking could strengthen these women to change their dysfunctional thoughts of self-blame and help them advance towards control of their lives, and empower them to seek support. Counselling using cognitive behavior therapies to deal with severe depression, anxiety and PTSD is essential [61, 62]. Moreover, providing older women with information and support through community outreach about the effects of abuse on coping and distress could help them to comprehend their situation and to reduce feelings of shame and lack of control [6]. It is beneficial to enhance women's wellbeing in terms of their rehabilitation and recovery from DV, particularly for those who wish to remain in abusive relationships.

Multi-agency intervention with older women is also needed and development of better collaboration between the aged, mental health, substance misuse, and domestic and family violence sectors to allow them to respond proportionately and with appropriate interventions. For instance, most Women's Aid shelters are not equipped to handle women with disabilities, or mental health disorders, and very few have separate programmes for this group of older women [63-65]. Similarly, the protective service system designed for elders has no methods for dealing with DV among older

women who do not qualify under elder abuse laws. Therefore if DV contributes to factors such as increased mental illness, and alcohol and drug abuse, then interventions aimed at these problems will not succeed without addressing DV in older women. In particular, reducing negative coping strategies such as avoidance, abuse of alcohol and drugs could ameliorate the negative impact of violence on older women's mental health and wellbeing.

## Conclusion

The World Health Organization states that the fundamental goals of public health are to preserve, promote and improve health [1]. Placing DV on the public health agenda is key to primary and secondary prevention: monitoring; increased public understanding of the nature, prevalence and impacts of DV; and establishing collaborative partnerships to enable an integrated response are all essential ingredients of developing best practice, along with programme evaluation [66, 67]. Our findings have implications for public health and interventions directed towards abused women, and contribute to our understanding of the importance of a high self-esteem and sense of coherence, and early intervention to prevent longer-term PTSD. This study allows the experience of DV to be assessed more holistically, and from the perspective of factors predisposing to 'wellbeing' as opposed to the more usual 'risk assessment' of factors predisposing to ill health. Support frameworks are urgently needed for women to develop adaptive coping resources to promote sense of coherence and psychological adjustment and encourage seeking of solutions to their abusive relationship, particularly for those remaining in one. Public health interventions can work well from a 'salutogenic' perspective by finding ways to promote healthy behaviours that increase older women's sense of wellbeing, coping and coherence and use of GRRs [68, 69]. In light of its influential role in understanding the capacity for coping and wellbeing, and multi-professional working, the application of the sense of coherence theoretical framework in this study offers the potential for new knowledge to contribute to the discourse about wellbeing in older women dealing with DV.

The study had limitations as the data were retrospective and self-reported. The sample was a small group of

women in middle age whose abuse experiences occurred over several decades. These findings may not correspond to women whose experiences of abuse are more recent, or to women at other life stages, however, they go some way towards our understanding of how older victims of DV have coped and currently cope with DV and may give insight into how to assist other women who remain in long-term abusive relationships. It would be of interest to conduct another study on this subject with a larger sample. Finally if research and service provision to this point focus only on women up to age 59, virtually the entire older half of the female population at risk of DV (those aged 60 to 85) are likely to be ignored [70]. This is highlighted in a recent UK report entitled '*Taskforce on the health aspects of violence against women and children*' [71] which states that the NHS has not taken violence against women seriously enough and that it must now do better. Although the report highlights that one in four UK women (28%) aged between 15 and 59 have experienced DV, it excludes all older women potentially experiencing the effects of lifelong abuse. As public health agencies accept the WHO <sup>9</sup>declaration that DV is a major public health concern, the importance must also be matched with resources for prevention initiatives.

## Disclosure

There are no conflicts of interest.

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